Mesenteric Vascular Insufficiency

IN THIS ISSUE Doctors Stemmer and Connolly present a highly readable compendium of clinical observations concerning the various pathologic disturbances of visceral blood supply. It is a thoroughly researched document which chronicles the entry of medical and surgical thought into an area which was once the sole domain of the physiologist. Since they first became aware of the increase of mesenteric blood flow that accompanies the entrance of food into the intestine, physiologists have sought to clarify the mysteries that influence visceral blood supply. They appear to have identified a unique and extremely sensitive vascular system which has an autoregulatory mechanism with vasomotor responses unlike those in other vascular systems. Exaggerations of these responses can precipitate profound pathologic disturbances. Examples are the spotty intestinal gangrene caused by clinical shock when other organ systems retain viability, and the massive intestinal necrosis in Gram-negative sepsis, left heart failure, and other chronic low output syndromes. That these can occur in the absence of occlusive lesions in the mesenteric vessels suggests a breakdown of the normal humoral and neural mechanisms that preserve intestinal blood supply.

Two California surgeons, Dunphy and Mikkelson, must be credited with beginning the new era in the clinical management of chronic visceral ischemic syndromes caused by mesenteric arterial disease. Although the existence of these syndromes had long been suspected, Dunphy was the first to show that symptoms of chronic postprandial abdominal pain were often premonitory to the appearance of fatal intestinal gangrene. Mikkelson almost 20 years later was the first to demonstrate that relief of these symptoms could be provided by surgical removal of an obstruction in a mesenteric artery. The accuracy of arteriographic diagnosis and the refinement of surgical techniques that have now made possible the successful reconstruction of occluded or stenosed mesenteric arteries have created new questions in diagnosis and management. Why is one so rarely able to demonstrate functional changes in the intermittently ischemic gut? Are there other intestinal syndromes besides the one characterized by epigastric pain after eating? Is prophylactic operation indicated for the asymptomatic patient with multiple visceral occlusive lesions? Is "mesenteric steal" a real syndrome since for it to occur one must postulate an amendment to the accepted rules governing blood flow? Should both arteries be reopened in the symptomatic patient with lesions obstructing both the celiac and superior mesentary artery? If only one artery needs revascularization, which should it be? In the absence of major differences in collateral blood flow, why do some patients with median arcuate compression of the celiac artery have severe pain relievable by operation while others are completely symptom free? It is to be hoped that in the foreseeable future another medical progress report will supply answers to these questions.

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On the Responsibility and Authority of Physicians

THERE IS MUCH to suggest that the responsibility and authority of the physician and of the medical profession have been in an overall decline for a number of years. There is also much to suggest that the medicine and the medicine man of the time have always been an essential component of any society, and that in a society as focused on health and well-being as is ours, there must be unparalleled opportunities for physicians and the medical profession to assume many responsibilities and to take many new kinds of authoritative actions for the betterment of the public health. It would seem that these are times for imaginative leadership and action by medicine and certainly not for abrogating the responsibility and authority of physicians.

There can be no question that the responsibility and authority of physicians have lessened con-

siderably in many aspects of patient care. The physician of yesteryear seldom gave detailed explanations; he made decisions in what he believed to be the interest of his patient, and he gave "orders." He did not even feel called upon to disclose the nature of the drug he was prescribing. He assumed both full responsibility and full authority. Now the law states that there must be full disclosure of all possible side effects and complications of any drug or procedure to be prescribed, and then the patient, having been fully informed and fully understanding, is supposed to make the decision. In hospital practice the "responsible" physician has come to share decision-making authority, and to a lesser extent responsibility, with a wide variety of intraprofessional and interprofessional specialists. These include quality control committees, utilization committees, nurse clinicians, health team managers and others. And where formerly the costs incurred and payment were largely a matter of responsibility and authority between physician and patient, this has now become a matter of responsibility and authoritative intervention by "third parties," including government, who pay more and more of the bills for patient care. It is not intended to say that this is all bad, but there have clearly been important changes in the authority and responsibilities of physicians which have altered patient care.

The emphasis on health and well-being which has developed in this nation during the last decade provides physicians and the medical profession with many new opportunities to assume responsibility and to act authoritatively, the authority being derived from the profession's knowledge, experience and expertise with respect to human health and its disorders and derangements. No other profession is as authoritative as medicine for this. It hardly needs to be argued that physicians and the medical profession indeed have an obligation to bring their knowledge, experience and expertise in human health authoritatively to bear, not only in the care of patients, but upon the problems of health care for persons not ill, upon what is now being called community medicine, upon the health care of the human environment and even upon the genetic care of the human species. It appears that to fulfill professional responsibilities throughout this spectrum of health care, which incidentally must also include the health of the delivery system itself, individual physicians and the profession as a whole should prepare themselves to:

- Give professional opinions based upon expert knowledge with respect to human health and its disorders,
- Participate in decision-making throughout the whole spectrum of health care, bringing the above expert knowledge to bear,
- Perform professional procedures and services as problem solvers, managers, skilled technicians, teachers or advisors, or advocates.*

It is suggested that if the above essential functions can be successfully performed throughout the whole spectrum of health care, the medical profession and organized medicine will have found a means to fulfill their obligations to their patients and to society within the modern context of medical and health care. This will require a substantial reassessment of what physicians should be doing and of what organized medicine should be doing, and of what they should be taught during their professional lifetime of undergraduate, graduate and continuing medical education. One can only wonder whether such a reassessment will occur, and if not, what the future holds for this profession.

—MSMW

*The physician and his practice: 1980-2000—Sixth Progress Report of the Committee on the Role of Medicine in Society, California Medical Association. Calif Med 116:71-95, Apr 1972.